Medicaid

Note: The following narrative is intended for informational purposes only. This description of the Medicaid program is not an official statement of policy that can be relied upon in lieu of the appropriate law, regulations, and rulings. This narrative is not intended to render legal or other professional advice; therefore, it should not be relied upon for making specific legal decisions. Instead the law, regulations, and rulings, should be consulted for purposes of making such decisions.

Title XIX of the Social Security Act is a federal-state matching entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments (which includes the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations, and policies, each state:

(1) establishes its own eligibility standards;

(2) determines the type, amount, duration and scope of services;

(3) sets the rate of payment for services; and

(4) administers its own program.

Medicaid policies for eligibility, services, and payment are complex and vary considerably even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state might not be eligible in another state; and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

Basis of Eligibility and Maintenance Assistance Status

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each state within federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional "state-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for state-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the AFDC program that were in effect in their state on July 16, 1996, or—at state option—more liberal criteria;
- Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL);
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care);
- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements which pre-date SSI);
- Recipients of adoption or foster care assistance under title IV of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time);
- All children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL. (This phases in coverage, so that by the year 2002, all such poor children under age 19 will be covered); and
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each state);
- Children under age 21 who meet the AFDC income and resources requirements that

were in effect in their state on July 16, 1996 (even though they do not meet the mandatory eligibility requirements);

- Institutionalized individuals eligible under a "special income level" (the amount is set by each state—up to 300 percent of the SSI federal benefit rate);
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers;
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;
- Recipients of state supplementary income payments;
- Certain working and disabled persons with family income less than 250 percent of FPL who would qualify for SSI if they did not work;
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs);
- "Optional targeted low-income children" included within the Children's Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997 (BBA97); and
- "Medically needy" persons (described below).

The medically needy (MN) program allows states the option to extend Medicaid eligibility to additional qualified persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their state's MN income level.

The medically needy Medicaid program does not have to be as extensive as the *categorically needy* program, and it may be quite restrictive in rules governing coverage and eligibility. Federal matching funds are available for MN programs. However, if a state elects to have a MN program, there are federal requirements that certain *groups* and certain *services* must be included. Children under age 19 and pregnant women who are medically needy must be covered; and prenatal and delivery care for pregnant women and ambulatory care for children must be provided.
A state may elect to provide MN eligibility to certain additional groups, and may elect to provide certain additional services within its MN program. In 1997, 42 states elected to have a MN program and provided at least some MN services to at least some MN recipients. All remaining states utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), known as the "welfare reform" bill, made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. This law impacts the Medicaid coverage for certain aliens. For legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, Medicaid is barred for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are state options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services which are mandatory). Although a number of disabled children lost SSI as a result of changes to P.L. 104-193, their continued eligibility for Medicaid was assured by Public Law 105-33—the Balanced Budget Act of 1997 (the BBA97).

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC), and replaced it with Temporary Assistance for Needy Families (TANF), which will provide grants to states to be spent on time-limited cash assistance. TANF limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other restrictions as well—in particular, requirements related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996, generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a new program initiated by the BBA97. In addition to allowing states to craft or expand an existing state insurance program, CHIP will provide more federal funds for states to expand Medicaid eligibility to include more children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from the CHIP also may be used for providing medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options for states to select for providing health care coverage for more children, as prescribed within the BBA97's title XXI program.

Medicaid coverage may begin as early as the third month prior to application—*if* the person would have been eligible for Medicaid had he applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA97 allows states to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

Scope of Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. These services generally include:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- vaccines for children;
- physician services;
- nursing facility services for persons aged 21 or older;
- family planning services and supplies;
- rural health clinic services;
- home-health care for persons eligible for skilled-nursing services;
- laboratory and X-ray services;
- pediatric and family nurse practitioner services;
- nurse-midwife services;
- federally qualified health center (FQHC) services and ambulatory services of an FQHC that would be available in other settings; and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds for certain *optional* services. The most common of the 34 currently approved optional Medicaid services include:

- diagnostic services;
- clinic services;
- intermediate care facilities for the mentally retarded (ICFs/MR);
- prescribed drugs and prosthetic devices;
- optometrist services and eyeglasses;
- nursing facility services for children under age 21;
- transportation services;
- rehabilitation and physical therapy services; and
- home and community-based care to certain persons with chronic impairments.

The BBA97 included a state option designated Programs of All-Inclusive Care for the Elderly (PACE). PACE provides an *alternative* to institutional care for persons aged 55 or older who require a *nursing facility level* of care. The PACE team offers and manages *all* health, medical and social services, and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive services. This care is provided in day health centers, homes, hospitals, and nursing homes, while helping the person maintain independence, dignity, and qualify of life. PACE functions within the Medicare program as well as under Medicaid. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both titles XVIII and XIX without amount, duration, or scope limitations, and without application of any deductibles, co-payments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Services

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services identified under the EPSDT program for eligible children that are within the scope of mandatory or optional services under federal law must be covered, even if those services are not included as part of the covered services in that state's plan and (2) states may request "waivers" to pay for otherwise uncovered home- and community-based services for Medicaid-eligible persons who might otherwise be institutionalized). States have few limitations on the services which may be covered under such waivers as long as the services are cost effective (except that, other than as part of respite care, they may not provide room and board for such recipients). With certain exceptions, a state's Medicaid plan must allow recipients to have some informed choices among participating providers of health care, and to receive quality care that is appropriate and timely.

Payment for Services

Medicaid operates as a vendor payment program. States may pay providers directly, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state generally has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. Excessive use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the BBA97, the state allotments for payments to DSH hospitals have become increasingly limited.

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid recipients for certain services. Certain Medicaid recipients, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid recipients must be exempt from co-payments for emergency services and family planning services.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent nor higher than 83 percent. In 1999, the FMAPs varied from 50 percent in 10 states to 76.78 percent in Mississippi. The BBA97 permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent, and raised the FMAP for Alaska from 50 percent to 59.8 percent for 3 years. For the children added to Medicaid through the CHIP program, the FMAP average for all states is about 70 percent, compared to the Medicaid average of 57 percent.

The federal government also reimburses state's for 100 percent of the cost of services provided through facilities of the Indian Health Service; provides financial help to the 12 states that provide the highest number of emergency services to undocumented aliens; and shares in each state's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities such as development of mechanized claims processing systems.

Except for the CHIP program and the QI program (described later). federal payments to states for medical assistance have no set limit (cap); rather, the federal government matches (at FMAP rates) state expenditures for the mandatory services plus the optional services that the individual state decides to cover for eligible recipients and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

Since its inception, Medicaid has had very rapid growth in expenditures. Although the rate of increase has subsided recently, the acceleration over the years has been noteworthy. This rapid growth in Medicaid expenditures has been due to several factors, primarily:

- The expanded coverage and utilization of services, and the increase in the size of the Medicaid covered populations (a result of federal mandates, population growth, and the earlier economic recession);
- The disproportionate share hospital (DSH) payment program, coupled with provider tax and donations programs;
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services;
- The results of technological advances to keep more very low-birth weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very expensive care; and
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year. Providing health care coverage for almost 17.5 million children, who otherwise would usually receive little or no medical care, has always been a primary concern of the Medicaid program. The data for 1997 indicate that Medicaid payments for services for these children (who constitute over 51 percent of all Medicaid recipients) average about $1,500 per child. However, certain other specific groups comprising far fewer persons have much larger per person expenditures. Regardless of their initial financial situation, their medical needs are so great and/or continuous that most of these patients must eventually depend upon Medicaid. When expenditures for these high and lower cost recipients are combined, 1997 payments to health care vendors for over 34 million Medicaid recipients averaged $3,680 per person.

Long-term care is an important and increasingly utilized provision of Medicaid—especially as our nation's population ages. Almost 45 percent of the total cost of care for persons using nursing facility or home health services in the United States in recent years is paid for by the Medicaid program. A much larger percentage is paid for by Medicaid, however, for those persons who use more than 4 months of such long-term care. The data for 1997 show that Medicaid payments for nursing facility (excluding Intermediate Care Facilities for the Mentally Retarded: ICF/MRs) and home health care totaled $42.7 billion for more than 3.4 million recipients of these services—an average 1997 expenditure of more than $12,340 per long-term care recipient. With the percentage of our population who are elderly and/or disabled increasing faster than the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, health maintenance organizations (HMOs), prepaid health plans (PHPs) or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is important to the Medicaid program. Section 1915(b) of the law allows states to develop innovative health care delivery or reimbursement systems. Section 1115 of the law allows statewide health care reform demonstrations for testing various methods of covering uninsured populations and testing new delivery systems without increasing costs. Finally, the BBA97 provided states a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care is growing rapidly. Several states have converted their entire Medicaid programs into managed care arrangements.

Medicaid data as reported by the states indicate that more than 34 million persons received health care service through the Medicaid program in 1997. Total outlays for the Medicaid program in 1997 included: direct payment to providers of $125 billion, payments for various premiums (for example, HMOs and Medicare) of more than $20 billion, payments to the disproportionate share hospitals of $15 billion, and administrative costs of $6 billion.

The total expenditure for the nation's program in 1998 was approximately $170 billion ($96 billion in federal and $74 billion in state funds). With anticipated impacts from the BBA97, projections now are that total Medicaid outlays may be $270 billion in fiscal year 2004, with an additional $6.6 billion expected to be spent for the new Children's Health Insurance Program.

Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For persons who are eligible for *full* Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program, according to eligibility category. These additional services may include—for example—nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always "payor of last resort."

Certain other Medicare beneficiaries may receive help through their state Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best known and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. This category includes persons who are eligible for full Medicaid coverage. For QMBs, the state pays the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) premiums and the Medicare coinsurance and deductibles, subject to limits that states may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, but still less than 120 percent of the FPL. For SLMBs, the Medicaid program only pays the SMI premiums. The Medicare law states that disabled and working individuals who previously qualified for Medicare because of disability but who lost entitlement because of their return to work (despite the disability) are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL, but who do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs). According to HCFA estimates, Medicaid currently provides some level of supplemental health coverage for 5 million persons who are Medicare beneficiaries in the above three categories for fiscal year 1996.

The BBA97 establishes a capped allocation to states for each of 5 years beginning January 1998, for payment of all or some of the Medicare SMI premiums for additional Medicare beneficiaries: those with incomes that are above 120 percent and less than 175 percent of the FPL. These income levels exceed those established for QMBs and SLMBs. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs who may be eligible for Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a state plan. The payment of this QI benefit is 100 percent federally funded, up to the state's allocation. This QI program provides financial assistance to additional persons needing help in acquiring adequate health care coverage.

Conclusion

The Department of Health and Human Services, the individual states, and the United States Congress continually seek to make improvements in the Medicare and Medicaid programs' coverage of needy individuals, and in the quality, effectiveness, and extent of health care services. However, these programs must function within the various federal and state constraints of serious economic, social, and political factors. As a result, federal and state regulations and laws continued to be reviewed for these very expensive, yet vitally important, Medicare and Medicaid programs.

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